ENDOSCOPY PROCEDURE INTAKE FORM

*****Please fill out completely*****

Date: _________ Primary Physician: ____________ Preferred Pharmacy: _________________

Patient Name: __________________________________ Previous last name: _______________

Date of Birth: _______________ Gender: Male Female

Address: ___________________ City: ___________ State: ____ Zip Code: _________

Home Phone: _____________________ Cell Phone: __________________________

Work Phone: ______________________ Email Address: _______________________

May we leave a message on your phone? ___ NO ___ YES

May we speak with another individual regarding your care? ___ NO ___ YES

If yes, list name, relationship and phone number: _______________________________
____

Primary Insurance Company: ___________________________

Insurance Phone # _________________ ID #_____________________Group # ______________

Secondary Insurance Company: _________________________

Insurance Phone # _________________ ID #_____________________Group # ______________

Prosthetics: (please circle all that apply) None, dentures-partials (upper / lower), glasses, contact lenses, hearing aid(s), other ___________________________________

Communication Barrier? ___ NO ___ YES Primary Language Spoken: ______________

Do you need an interpreter? ___ NO ___ YES

Previous Endoscopies:
Colonoscopy: __ NO __YES if yes, when and where: __________________________________

Upper Endoscopy (EGDs): __ NO __YES if yes, when and where: ________________________

Flexible Sigmoidoscopy: __ NO __ YES if yes, when and where: ________________________

Antibiotics: Do you take an antibiotic before routine dental cleanings? ___ NO ___ YES If yes, list antibiotics prescribed: ____

Ambulatory Aides: (please circle all that apply) None, Cane, Walker, Wheelchair

Height: _______Weight: _________

MEDICAL HISTORY

Cardiovascular - Heart Disease: (Please circle all that apply) None known, Heart attack, High blood pressure, Congestive heart failure, Mitral valve prolapse, Heart murmur, Coronary heart disease, Valve replacement, Bypass surgery, Angioplasty, Defibrillator (AICD), Pacemaker, Arrhythmias, Endocarditis/Pericarditis
Other____
Do you currently have chest pain, pressure, or palpitations? _____NO _____YES

Pulmonary Disease – Breathing problems (Please circle all that apply) None known, COPD, Emphysema, Sleep Apnea, Asthma, Bronchitis, Oxygen at night, Continuous Oxygen (LPM____), CPAP, BIPAP, Other (please explain)
____

Are you Diabetic? _____ NO ______YES
Are you treated with (circle all that apply) Diet, Insulin, Oral medication
If yes, average blood sugar: ___________ Does your blood sugar drop easily? ___NO___YES

GI Disorders: Stomach or Bowel problems (Please circle all that apply)
Constipation, Bloating, Rectal Bleeding, Abdominal pain/ discomfort, Diarrhea, Acid Reflux, Food sticking in throat, Hemorrhoids, Crohns, Ulcerative Colitis, Irritable Bowel
How many bowel movements do you have in one week? _________

Liver Disease: (Please circle all that apply) None Known, Cirrhosis, Hepatitis, Jaundice
Date of Diagnosis: _____________________

Kidney Disease: (Please circle all that apply) None Known, Renal failure acute, Renal failure chronic, Dialysis, Fistula (Right arm or Left arm)

Family History of Cancer: ____NO ___YES if so, Relation: _________________
Type: ____

Personal History of Cancer: ___ NO ___YES; **Type:**____________ Date diagnosed________
Treatment: ____
Do you have a: Port _______ PICC Line ________

Other Medical Illnesses: (Please circle all that apply)
None Known, Arthritis, Blood disorders, Anemia, Problems with Central Nervous System, Stroke, Stroke symptoms, Depression, Anxiety, Seizure disorder, Epilepsy, Thyroid Problems, Fibromyalgia, Glaucoma, Macular degeneration, High Cholesterol, Musculoskeletal problems, Other: ____
____

Do you have a history of any of the following Diseases? (Please circle all that apply)
None Known, HIV, Hepatitis, Shingles, Herpes, MRSA, TB, Cold Sores
if so, please explain: ____

Could you be pregnant? ____ NO ____ YES

Have you or immediate family members traveled outside the US in the last month?
_____NO _____YES **If yes, please list dates/location of travel:** ________________________

PATIENT NAME:__________________________DOB:__________

SURGICAL HISTORY

(Please circle all that apply) NONE, Appendectomy, Gall Bladder surgery, Hysterectomy, Hernia repair, Cervical spine surgery, Lumbar spine surgery, Tonsillectomy,
Other: ____

____

Cataract Surgery: ___ NO ___ YES Date of Surgery: __________________

Joint Replacement: ___ NO ___ YES Date of Surgery: ______ Surgeon: _______________

Joint Replaced: ______________________________

Transplants: (Please circle all that apply) NONE, Heart, Heart/Lung, Lung, Kidney, Liver, Pancreas, Other: ____

Anesthesia: Have you or any family members had problems with anesthesia/sedation?
___NO __ YES If yes, list who and reaction: ____

Do you have an Advanced Directive? ____NO _____ YES

SOCIAL HISTORY

Do you drink alcohol? ____ NO ____ YES **if yes, Amount per**: ____ day ____ week ___ month

Have you ever smoked/chewed tobacco? ___ NO ___ YES **if yes, Amount**: _____
Number of Years: ______Quit Date: ________

Do you use street drugs? ___ NO ____ YES
if yes, please specify name of drug: ____________________

Do you have a history of street drug use, or alcohol or substance abuse? ___ NO ___ YES
If yes, Substance __________Amount: ______ **Duration**: ________ **Quit Date**: _________

ALLERGIES (Please check all that apply) NONE KNOWN

Soy	____ NO	____ YES	Reaction: ______________________________
Peanut	____ NO	____ YES	Reaction: ______________________________
Egg	____ NO	____ YES	Reaction: ______________________________
Latex	____ NO	____ YES	Reaction: ______________________________
Iodine	____ NO	____ YES	Reaction: ______________________________
Lidocaine	____ NO	____ YES	Reaction: ______________________________

Other Allergies:

___________________________ Reaction: ______________________________
___________________________ Reaction: ______________________________
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PATIENT NAME:__________________________DOB:__________

**Please turn page over –

CURRENT MEDICATIONS: Include all over the counter medications (i.e. Tylenol, Aspirin, Vitamins, etc.)

Medication	Dose	AM / PM	How Often taken____

Thank you for completing the questionnaire

When we receive your questionnaire, you will be contacted to schedule your procedure for the next available appointment. We may need to ask follow up questions. We will ask about your preference for sedation and will give you instructions regarding your procedure.

You are responsible for checking with your insurance company about coverage; if pre-authorization is required, and if The Endoscopy Center is within network for your insurance plan.

Please return this form to:

GI Procedure Scheduling
Rapid City Medical Center, LLP
2820 Mt. Rushmore Road
Rapid City, SD. 57701
605-342-3280, ask for GI Procedure Scheduling (Extension 7550)
800-336-3503 Ext: 7550
Fax: 605-721-4066

PATIENT NAME:___________________________DOB:__________